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ANXIETY NEUROSIS—A PSYCHIATRIC EVALUATION

Introduction: Anxiety is familiar to everyone as a personal experience, occurring either at times of danger or at times of actual or threatened loss of money, loved ones, job, or the like. This familiar anxiety is due to some danger in the environment, an external danger.

This common and normal feeling becomes pathological when it is greater than the external environmental situation seems to call for, or where the feeling of anxiety is present without an obvious external danger. In such a case the individual has something within himself about which he feels anxious, something which threatens him from within such as unwelcome instinctual impulses or thoughts. This inner danger is comparable to external stress in its ability to produce anxiety. This anxiety[1] has come to be recognized as common to all the neuroses, whatever the other special neurotic symptoms—obsessions, phobias, or hysterical conversions—which are used in an attempt to ward off the anxiety.

There are people, popularly called nervous, who are anxious people, with a sense of inner tension which makes them more vulnerable to any outside environmental stress which can touch upon the psychic tension or enflame it, so that when disturbing events or chronic trying life situations occur, they may develop symptoms, the particular type of symptoms depending on the bent of the individual. One particular collection of symptoms having a fairly uniform expression is called anxiety neurosis; and it is to this illness that we direct our attention, remembering that by doing so we are narrowing the subject to a peripheral, symptomatic diagnosis.

Definition: The anxiety neurosis is an illness with the psychic symptoms of general irritability, apprehension and fear, anxious expectation, and a sense of tension, usually accompanied by a variety of somatic symptoms of activity of the autonomic nervous system, including dizziness, palpitation, difficulty in breathing, smothering sensations, etc. The fear may be unattached and apparently objectless or may be directed toward one of the organs involved. For example, if there is a sense of constriction of the throat, the patient may think he is choking. If there is throbbing in the head, the patient may think he is having a stroke, or if pounding of the heart or heaviness in the chest, he may think that his heart is diseased. The patient may emphasize these local symptoms and minimize the idea of the anxiety behind it. *Cardiac neurosis* has been used in two different ways to describe these cases: (1) Where the cardiac symptoms, i.e., palpitations, cardiac consciousness and pains in the precordial region predominate, and where the patient has some degree of belief that he has heart disease, or (2) if he has organic heart disease that the disability is out of proportion to it. The term cardiac neurosis, therefore, is used as either a (1) form of anxiety neurosis with an added psychic complication of more or less fixation on the heart, i.e., hysteria, or (2) the added element of psychic fixation which occurs in some cases of organic heart disease, i.e., an hysterical elaboration. These two are not the same, but have the common denominator of hysterical

SCIENTIFIC SESSION

The Annual Meeting and Twenty-Fifth Scientific Session of the American Heart Association will be held at the Hotel Statler, Cleveland, Ohio, April 18-20, 1952. All of those planning to attend should make room reservations directly with the Housing Bureau, Mr. Martin C. Dwyer, 511 Terminal Tower, Cleveland, Ohio at the earliest possible date.

fixation on the heart. Thus, to a psychiatrist, cardiac neurosis is conversion hysteria.

Historical: Anxiety neurosis was a term first used by S. Freud in 1895[2] to separate from the mixture of illnesses then called neurasthenia those cases with anxiety and fear, or anxious expectation predominating. Neurasthenia (nervous exhaustion) was a term widely used in the late 19th and early 20th century to describe certain states of fatigue or easy fatiguability, or tired feelings, with insomnia, constipation, full feeling in the head, headaches, irritability and depression. After eliminating depressions, fatigue states and various diseases then not known, and after the anxiety neurosis is taken out of this group, there is almost nothing left to neurasthenia. However, in certain chronic cases of anxiety neurosis the fatigue and tired feelings are outstanding symptoms. A most important feature of the anxiety neurosis is discussed by Freud, namely, that it very often occurs in combination with the neurasthenic symptoms and with various psychoneuroses, hysteria, and phobias.

Relationship of anxiety neurosis to neurocirculatory asthenia and the effort syndrome: In the American Civil War, first Hartshorne[3], then DaCosta[4] described a condition of palpitation, tachycardia, chest pain and fatigue without physical heart disease. In the First World War, many of these cases were seen and described as effort syndrome[5] or neurocirculatory asthenia[6]. In the recent war, many of the cases of psychoneurosis and combat fatigue have been seen to be identical in symptomatology. T. Lewis[5] stated of the patients with effort syndrome that they are not of the average normal psychologically, have many minor fears and phobias, depressive tendencies, sexual activities are not average, and have hysterical fainting attacks, and childhood history of nervousness and frights. The English group[7] in World War II in studying this syndrome have concluded that it is a symptom-complex occurring usually with some psychiatric disease and not a disease in itself. They described: anxiety states, hysteria, neurotic depressions, psychopathic personalities (the English term for neurotic individuals) and rarely schizophrenia. In fact, even in DaCosta's original paper, his first case description also had an aphonia with little physical basis, complained of frequent nocturnal emissions, and indeed reads like a case of hysteria.

Chest pain, an especially prominent feature of effort syndrome, has puzzled some investigators, and sometimes by its superficial similarity to angina pectoris has made diagnosis difficult. This pain, investigated carefully by Wood[7], is seen to be of hysterical nature in some cases, or the hysterical elaboration of various thoracic cage pains in other cases. The possibility that there may be a psychosomatic alteration such as muscle spasm causing the pain is not entirely eliminated. Chest pain was not mentioned by Freud as a prominent symptom of anxiety neurosis although the term "cardiac spasms" is used. However, the other symptoms are so nearly identical in all respects that one may conclude that neurocirculatory asthenia is a form of anxiety neurosis, and that the pseudoanginal pain is of hysterical origin. Psychologically, effort syndrome seems to occur when the patient with anxiety neurosis feels himself to be in a passive and helpless or defeated state of mind. Our experience is that the effort syndrome will get better or worse in cases under psychiatric treatment, depending on the degree of optimism the patient has of getting out of his difficulties. These clinical observations are not surprising when one considers that recently it has been shown experimentally that in anxious persons with effort intolerance on standard work tests there was improvement in performance during periods of relative security and relaxation[8].

Pathological Physiology—It is impossible to review in a few words the great quantity of work done or being done on the various physiological aspects of anxiety neurosis. In summary one could say that no specific somatic causes have as yet been found, although many excellent well-controlled studies have been done. There are interesting physiological accompaniments of the anxiety state, e.g. reduced exercise tolerance[8], reduced ventilatory efficiency[9], and many others of a reversible nature as far as one can tell at present.

Diagnosis: Among psychiatrists nowadays it is somewhat unusual to see patients with a pure anxiety neurosis without some hysterical or phobic symptoms also, although these will sometimes not be noted by the casual observer or by one unskilled in psychiatric diagnosis. That is, upon close questioning, it is possible with most patients to elicit the history of having psychological as well as somatic symptoms, e.g., having always been nervous or easily upset, having minor fears such as fear of heights, of the dark, or of bodily injury. With one type of individual with disease of relatively acute onset there may be a dearth of these fears and the personality will seem to have been free of anxiety or fears. Such people who seem free of anxiety will be found to use the hysterical mechanisms of denial and repression in the face of obvious environmental difficulties or stresses. Anxiety neurosis, therefore, is not strictly a diagnosis but refers to a symptomatic state occurring in any one of the psychoneuroses and sometimes in a psychosis.

For example, in a group of seventy-nine military cases seen by this author during World War II, diagnosed effort syndrome and neurocirculatory asthenia, phobias of some degree, usually mild, occurred in 78% of cases as compared to 26% among a group of fifty-three healthy men used as controls. Most cases severe enough to be considered by medical men for psychiatric referral are cases of hysteria or anxiety hysteria (phobia). E.g., in the case of a young soldier, Private A. P., with chief complaint of "skipping" heart beat, who also had fatigue, palpitation and pain in chest, the patient described his own personality as always easily upset, was afraid of the dark, and said he had been a shy child. He had worried about masturbation, was afraid of people in authority and afraid he might do something wrong. This is a type of chronic anxiety state with mildly phobic symptoms of a degree which is not crippling, seen in many cases of anxiety neurosis, and is more properly called anxiety hysteria.

Differentiating the disorder from various medical illnesses is sometimes a problem. Cases seen by the psychiatrists have often been treated previously as one of a variety of disorders. Angina pectoris, "murmurs," hyperthyroidism, hypothyroidism, and cardiac dysrhythmias are the most common diagnoses. Cases in which a prominent feature is the giddiness or dizziness have often been treated as Menière's disease. Cases with the characteristic throbbing in the head are often called migraine. If indigestion is also outstanding, the diagnosis of ulcer or gastric neurosis may have been made. Cases are sometimes seen in a diagnostic center, where the patient has been allowed to stay in bed for months or years because of this illness, where the mistaken diagnosis of heart disease or questionable heart disease added to the patient's apprehension and desire to remain in bed has unnecessarily made him an invalid.

There are cases of unmistakable heart disease where in addition to the organic cardiac symptoms there are the symptoms of anxiety neurosis. Here, the degree of cardiac disease must be properly assessed as well as the degree of anxiety neurosis. The subject might have had an anxiety neurosis or have been an anxious person whether or not he had any degree of heart disease, but sometimes the fact of having heart disease will alter the ordinary way of life to which he was adjusted, thereby weakening his customary means of controlling his anxiety. This type of case may be seen in persons who have only a mild degree of neurosis not expressed clinically, quite well concealed until organic heart disease comes along. Then the patient's latent anxieties are aroused by the weakness he feels from the discovery that he can no longer have his full powers, and he becomes anxious beyond the expectations set by his organic disease.

Certain diseases of the brain which apparently weaken the subject's ability to cope with latent emotions may cause pathological anxiety states. For example, early general paresis, multiple sclerosis, cerebral arteriosclerosis, or even brain tumor or abscess may occasionally have some symptoms of anxiety neurosis, and it is especially important in the early stages of these diseases, where the neurological signs may not be clear, to make a correct diagnosis of the organic neurological disease. It is possible to have two diseases which affect each other. Sometimes an undiagnosed early tuberculosis or undulant fever will create symptoms of fatigue, which, due to their weakening effect on the patient's ability to deal with his problems plus the worry over a disease the physician seems unable to explain, will precipitate a state of anxiety. These represent a very small proportion of the great number with anxiety neurosis.

Treatment: Pathological anxiety occupies a place in psychiatric disease similar to that of fever in inflammatory illnesses. One would not speak of treating fever nowadays, but of treating the illness of which it is a symptom. Similarly, treatment in anxiety neurosis will depend on the severity of the neurosis of which this symptom-complex is a part, judging severity by (1) duration, (2) by extent of crippling of the activity, (3) extent to which individual has accepted the limits set by the neurosis and therefore may not want to change.

There are many mild cases which never come to the psychiatrists and are treated with reassurance and explanation alone—resulting in complete symptomatic recovery. Following is an example:

Case #1—A 38 year old married woman, Mrs. G., anxious about her heart, had lost confidence in her physician when another patient of this same physician, whom she knew, died suddenly without warning. She got panicky spells, was short of breath on exertion, became afraid to go out into the street (agoraphobia). She was seen in consultation, reassured, and some of her personal problems discussed including her lack of confidence in the physician. Within two weeks, she had lost her symptoms including both the phobia of going out and the shortness of breath and palpitation. When retested upon exercise tolerance tests, she showed an improvement in breathing, having lost her dyspnea altogether, although she continued to show tachycardia without discomfort. She will continue to be an anxious person, but will have lost the acute symptoms.

A mild case would be one in which, under a lot of external stress, a fairly well-functioning individual has developed a few anxiety attacks. E. g., a man who has been able all his life to ward off anxiety by work and activity will very likely be able to do so again as soon as he sees that his physical disease is controlled. Providing he has confidence in the physician, he may never come to the psychiatrist. Some patients are afraid they will die or the heart will wear out sooner than it should because of its overactivity. Since it has been shown statistically in good follow-up studies that anxiety neurosis does not shorten life, it is with a good conscience that the physician can reassure the patient on this point.

At the other end of the scale is the young adult with attacks of chest pain on exertion who thinks he has heart disease, or has had anxiety attacks since childhood, has lived under the need to have something to shield himself from the buffets of life. This is a severe hysteria with hypochondriacal fixation. Or a woman aged thirty who has had fatigue symptoms since adolescence and has anxiety attacks in crowds. She has sexual frigidity, is hostile to her husband, cannot face her housework without taking benzedrine or barbiturates, or both. Such a person has a complicated personality problem with drug addiction and will require thorough psychotherapy by a psychiatrist or a psychoanalyst. With severe cases that do not respond to suggestion and explanation, the physician can help chiefly by two things: (1) Doing a thorough examination and (2) by not complicating the psychiatric treatment with treatment of conditions the patient does not have. The physician must create the impression of conviction that he knows the diagnosis and understands the illness. If he has a neurosis don't tell him there is nothing at all wrong. It is also important to explain in his referral to the psychiatrist just what the referral is for, whether for diagnosis or treatment, and to avoid frightening names which have reference to the heart or to mental illness. The special significance of the anxiety neurosis for therapy is that it indicates an apprehensive, suggestible individual, ready to take on new symptoms or get rid of old ones if conditions are right.

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PROGRAM COMMITTEE

The Chairman of the Program Committee for the Annual Scientific Session is Doctor Irvine H. Page, Cleveland Clinic, 2020 East 93 Street, Cleveland 6, Ohio. All who desire to present papers at the meeting in Cleveland should forward to Doctor Page an abstract (in triplicate) of the proposed presentation of not more than 300 words. As a departure from previous practice, arrangements will be made at this meeting for a special session to present papers dealing with the basic science aspects of cardiovascular disease. The deadline for the receipt of abstracts is January 1, 1952.

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